

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72-hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09361

9383

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#1- Bush River area</u>		d. STREET ADDRESS <u>Bush River area</u>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Nelson</u> Last <u>Boyer</u>		4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/1898</u>
9. AGE (In years lost birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Effie L. Michael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Oliver P. Boyer Jr.</u>		Address <u>Aberdeen #1- res.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hematemesis</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Pancreas i metastases</u> DUE TO (c) <u>6 mo.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1947</u> , 19 to <u>9-5-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-4-56</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Rodman</u>		ADDRESS (Street, city or town, state) <u>Aberdeen, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/7/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spesantia cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barrington</u>		ADDRESS <u>Aberdeen res.</u>	
24a. REC'D BY REGISTRAR <u>Sept 7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mellie R. Perry</u>	

# CERTIFICATE OF DEATH

RECEIVED  
SEP 10 1956  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09362

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNS</u> b. COUNTY <u>Polmeroy</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harford Grace</u>		c. LENGTH OF STAY IN lb <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Polmeroy</u>		d. STREET ADDRESS <u>752-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>T.</u> Last <u>Coldwell</u>				4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 2, 1882</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Civil G. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rev. M. Caldwell</u>				14. MOTHER'S MAIDEN NAME <u>Jane Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Parents Funeral Home, Coatsville Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO cause lost. (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cypress</u>		22d. LOCATION (City, town, or county) (State) <u>Chester Co. Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rev. White Funeral Home</u>				ADDRESS <u>103 E. Lincoln Hwy</u>		24a. REC'D BY REGISTRAR DATE <u>9-16-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>G. H. Lewis M.D.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

SEP 18 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9384 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09363

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> c. LENGTH OF STAY IN lb <u>92 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>RD 2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>William</u> First <u>E</u> Middle <u>Cooper</u> Last				<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>10</u> Year <u>1956</u>			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>E</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb. 26, 1864</u>	
<b>9. AGE</b> (In years last birthday) <u>92</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Owner</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Nathan E. Cooper</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>William E. Cooper, Bel Air, R.D.#2</u> Address <u>Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Gerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				<b>DATE SIGNED</b> <u>9/10/56</u>			
<b>EXAMINER'S NAME (Type)</b> <u>Gerald C Palmer, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Feb 13, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Asbury</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Churchville, Harford, Md</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Howard K. McComas &amp; Son</u> ADDRESS <u>Abingdon, Md.,</u>				<b>24a. REC'D BY REGISTRAR</b> <u>Powell</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Lowwood</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



NEW YORK STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 51

SEP 18 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom of the certificate may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9385

## CERTIFICATE OF DEATH

09364

Reg. Dist. No. 180

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		STATE <u>MARYLAND</u>		COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>RURAL JOPPA</u>		LENGTH OF STAY (in this place) <u>2 YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL JOPPA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 366 RFD #1</u>				STREET ADDRESS (If rural give location) <u>Box 366 RFD #1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>SARAH ELIZABETH DICKINSON</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>SEPT. 18 19 56</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JULY 23, 1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>DETER LAWRENCE</u>				14. MOTHER'S MAIDEN NAME <u>MARY FULLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>224-14-649B</u>		17. INFORMANT & ADDRESS <u>EVELYN MYERS, JOPPA, MD</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Arterio Sclerosis</u>						<u>Over 4 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Cardiovascular disease with Cardiac Hypertrophy.</u>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 19 53</u> to <u>Sept 19 56</u> , that I last saw the deceased alive on <u>Sept 18 19 56</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Khurman</u>				ADDRESS (Street, city, town, state) <u>M.D. 307 Hickory, Bel Air, Md</u>		DATE SIGNED <u>Sept 18 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 22 56</u>		NAME OF CEMETERY OR CREMATORY <u>Leemont</u>		LOCATION (City, town or county) (State) <u>Danville Va</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Norma G. Moore</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer</u>		ADDRESS <u>Benson Md</u>	
DATE <u>SEP 21 1956</u>							

NEW YORK STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

BUREAU V. 8

SEP 21 1956

RECEIVED



9386

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Varrettsville</u>		c. LENGTH OF STAY IN 1b <u>52 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) <u>MARY ANN EMRICK</u>		4. DATE OF DEATH <u>Sept 23 - 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 15<sup>th</sup> 1888</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Fawn Grove Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FELIX H. KUNKEL</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE THOMPSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wm M. Emrick White Harford, Md</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA RT LUNG</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTIO SCLEROTIC HT. Diseases</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>10 years</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PSYCHOSIS - Type NOT KNOWN - PROBABLY Paranoia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 22, 1956</u> , to <u>Sept 23, 1956</u> , that I last saw the deceased alive on <u>Sept 23, 1956</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. James Thompson</u> M.D.		ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>9/25/56</u>	
PHYSICIAN'S NAME (Type) <u>Samuel James Thompson, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 26-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fawn Grove Meth.</u>	22d. LOCATION (City, town, or county) (State) <u>Fawn Grove Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skurtz</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
ADDRESS <u>—</u>		DATE <u>9-27-56</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9258

## CERTIFICATE OF DEATH

09366

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Harford Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>13 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>none</u>		d. STREET ADDRESS <u>141 Wilson</u>	
3. NAME OF DECEASED (Type or print) <u>Lydrea Alice Friend</u>		4. DATE OF DEATH <u>9/11/56</u> 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Haydon, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Van Riehl</u>		14. MOTHER'S MAIDEN NAME <u>Phoebe Mangus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>John W. Roney</u>		Address <u>141 Wilson, Harford</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>Diabetes Mellitus &amp; coma</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Myocarditis</u> DUE TO (c) <u>Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 days</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>Sept</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>56</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Wolbert MD.</u>		ADDRESS (Street, city or town, state) <u>HARFORD DE GRACE MD</u> DATE SIGNED <u>9/11/56</u>	
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD.</u>		DATE SIGNED <u>9/11/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/14/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green</u>	22d. LOCATION (City, town, or county) (State) <u>Rowan, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank W. Roney</u>		ADDRESS <u>141 Wilson, Harford</u>	
24a. REC'D BY REGISTRAR <u>DATE 5262-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9369

## CERTIFICATE OF DEATH

09367

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		LENGTH OF STAY (In this place) <i>25 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>552 St. Clair St.</i>				STREET ADDRESS (If rural give location) <i>552 St. Clair St.</i>			
3. NAME OF DECEASED (Type or Print) <i>Arthur Hawkins</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>9 26 19 56</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>		8. DATE OF BIRTH <i>10-3-1885</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Government</i>		9. AGE last birthday <i>70 yrs.</i>		IF UNDER 1 YEAR Months <i>11</i> Days <i>26</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Richard Hawkins</i>				14. MOTHER'S MAIDEN NAME <i>Eliza Floyd</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-14-4044</i>		17. INFORMANT & ADDRESS <i>Mo Eva Hawkins Harre de Grace, Md</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Pulmonary Edema</i>						<i>1 day</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Myocardial Failure</i>						<i>1 month</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Chronic Nephritis with Uremia</i>						<i>1 month</i>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 19 56</i> , to <i>Sept 26 19 56</i> , that I last saw the deceased alive on <i>Sept 26 19 56</i> , and that death occurred at <i>7:45 P.</i> M., from the causes and on the date stated above.							
SIGNATURE <i>John W. Herbert M.D.</i>				ADDRESS (Street, city, town, state) <i>Harre de Grace Maryland</i>		DATE SIGNED <i>9/27/56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Sept. 30, 1956</i>		NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		LOCATION (City, town, or county) (State) <i>Harre de Grace, Md</i>	
24. REC'D BY REGISTRAR <i>Sept 28 56</i>		REGISTRAR'S SIGNATURE <i>G. H. Lewis M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullock</i>		ADDRESS <i>Harre de Grace</i>	



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1901

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
9370 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 185-										
1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>			c. LENGTH OF STAY IN 1b <b>13 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whiteford</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hosp.</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>PATRICK</b> Middle <b>FRANCES</b> Last <b>HUSHON</b>					4. DATE OF DEATH Month <b>Sept.</b> Day <b>18</b> Year <b>19 56</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-29-1873</b>		9. AGE (In years last birthday) <b>82</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT GENERAL</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Patrick Hushon</b>					14. MOTHER'S MAIDEN NAME <b>MATILDA Mc MILLIAN</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-18-9341</b>		17. INFORMANT <b>Joseph Hushon Delta PWH, Pa.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage accompanying contusion of the scalp</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by auto</b>								
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>9/15/56</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) <b>Whiteford</b>		20g. (County) <b>Maryland</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>R S Fisher</b>					M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-20-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S</b>			22d. LOCATION (City, town, or county) (State) <b>PPLESVILLE, HARFORD CO., Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth W. Fisher</b>					ADDRESS <b>Stewartstown Pa</b>		24a. REC'D BY REGISTRAR DATE <b>Sept. 20</b>		24b. REGISTRAR'S SIGNATURE <b>St. G. H. Hession</b>	

10351

Reg. Dist. No. 185-

MEDICAL CERTIFICATION

SEP 21 1956

BUREAU V.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09368

9371

## CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <u>Harford</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8 Battle Street</u>			
				d. STREET ADDRESS <u>Edgewood, Md.</u>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Jones</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-1895</u>	
9. AGE (In years lost birthday) <u>61</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Housing</u>		11. BIRTHPLACE (State or foreign country) <u>Butterworth, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>730/19184 7/22/1919 - 23-01-6403</u>		17. INFORMANT <u>Mrs. Myers - Federal Housing, Edgewood, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Hypertensive Arterio sclerotic Heart disease</u> DUE TO (c) <u>Hypertensive Arterio sclerotic Heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u> <u>21 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/1</u> , 19 <u>54</u> , to <u>9/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/26</u> , 19 <u>56</u> , and that death occurred at <u>10:05 A. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u> , M.D.				ADDRESS (Street, city or town, state) <u>549 Revolution St., Harre de Grace, Md.</u>			
DATE SIGNED <u>9/26/56</u>							
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				CITY OR TOWN <u>Harre de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>October 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock - Harre de Grace, Md.</u>				24a. REC'D. BY REGISTRAR <u>Oct 1 - 56</u>		24b. REGISTRAR'S SIGNATURE <u>G. H. Henrich, Md.</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09369

9372

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				d. STREET ADDRESS <u>7314 Main Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Han</u> Last <u>Lamm</u>				4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-1882</u>		9. AGE (14 years last birthday) <u>73</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Port Deposit, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Martha (Hall)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Florence L. Gibson</u> Address <u>Port Deposit, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per type for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>S.D. hemiplegic cause undetermined</u> <u>78x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Aug 2, 1956</u> to <u>Aug 3, 1956</u> that I last saw the deceased alive on <u>Aug 3, 1956</u> , and that death occurred at <u>12:00 A.M.</u> from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE <u>Wm K. Brendle</u>		M.D.		ADDRESS (Street, city or town, state) <u>HARRE DE GRACE, MD. 2-5-56</u>			
PHYSICIAN'S NAME (Type) <u>Wm K. Brendle</u>		M.D.		<u>HARRE DE GRACE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-6-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) <u>Port Deposit, Md.</u>		(State) <u>Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson &amp; Son</u>				ADDRESS <u>Ferryville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 9-6-56</u>	24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>

BUREAU V. S.

SEP 7 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 Film 0207 11-26-56 et

09370

9373

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Havre de Grace</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Havre de Grace</i>	(If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>519 Alliance St.</i>		STREET ADDRESS <i>417 Lafayette St.</i>	
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Angeline</i> (First) <i>Leggar</i> (Middle) <i>Leggar</i> (Last)		<b>4. DATE OF DEATH</b> (Month) <i>9</i> (Day) <i>29</i> (Year) <i>1956</i>	
<b>5. SEX</b> <i>Female</i>	<b>6. COLOR OR RACE</b> <i>Negro</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>married</i>	<b>8. DATE OF BIRTH</b> <i>Unknown</i>
<b>9. AGE last birthday</b> <i>70</i> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U. S. A.</i>	
<b>13. FATHER'S NAME</b> <i>Sidney Butler</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Elizabeth (unknown)</i>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <i>none</i>	
<b>17. INFORMANT &amp; ADDRESS</b> <i>Mr. Robert O. Harris - Havre de Grace</i>		<b>18. MEDICAL CERTIFICATION</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <i>Uremia</i>			
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Arteriosclerotic Heart disease</i>			
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>	
		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <i>4/10</i>, 19<i>56</i>, to <i>9/29</i>, 19<i>56</i>, that I last saw the deceased alive on <i>9/29</i>, 19<i>56</i>, and that death occurred at <i>11:45 A.M.</i> from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <i>George J. Stansbury</i>		<b>DATE SIGNED</b> <i>9/29/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>24. REC'D BY REGISTRAR</b>	
<b>DATE THEREOF</b> <i>10-2-56</i>		<b>REGISTRAR'S SIGNATURE</b> <i>W. L. Hamilton</i>	
<b>NAME OF CEMETERY OR CREMATORY</b> <i>St. James Cemetery</i>		<b>LOCATION (City, town, or county)</b> <i>Havre de Grace, Md.</i>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Otelia J. Bullock</i>		<b>ADDRESS</b> <i>Havre de Grace, Md.</i>	
<b>DATE</b> <i>10-2-56</i>			

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS AISC 1-53 10M

BUTLER V. S.

OCT 4 1956

RECEIVED

9374

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haver de Grace</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Long BAR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Virginia</u> Last <u>Longley</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/9/1867</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Q. Carrell</u>				14. MOTHER'S MAIDEN NAME <u>Alice Jane Sluss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Wilhelmina Weidman</u> Address <u>613 Plymouth Rd. Balt., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic C.V.D. disease</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic pneumonia, left</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1944</u> to <u>Sept 1956</u> , that I last saw the deceased alive on <u>Sept 8, 1956</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph Horkey</u> M.D.				ADDRESS (Street, city or town, state) <u>Churchville</u> DATE SIGNED <u>Sept 9</u>			
PHYSICIAN'S NAME (Type) <u>J. Ralph Horkey MD</u>				<u>Churchville - Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 12, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs &amp; Son</u>				ADDRESS <u>Abingdon Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9-14-56</u> 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



JOHN W. B.

SEP 17 19

1917

## 9387 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY OR TOWN Bel Air R.D.		LENGTH OF STAY (In this place) Lifetime		CITY OR TOWN Bel Air R.D.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) (Residence on a farm)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Samuel		(Middle) S.		(Last) Magness			
5. SEX male		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Nov. 27, 1891	
				9. AGE last birthday 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Thomas Magness				14. MOTHER'S MAIDEN NAME Irene Knight			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) yes WW I				16. SOCIAL SECURITY NO. 213-36-8748		17. INFORMANT & ADDRESS John Henry Magness, Bel Air Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INSTANT	
IMMEDIATE CAUSE (A) CORONARY OCCLUSION							
ANTECEDENT CAUSE(S) DUE TO CORONARY OCCLUSION 8 years ago - on Dicuminal for 8 years						8 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Followed every 2 weeks at Mary Hosp.							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 18, 1956, to Sept. 18, 1956, that I last saw the deceased alive on NEVER and that death occurred at 9:30 AM, from the causes and on the date stated above.							
HIGH TIME Philip W. Heumann Deputy Medical Examiner M.D. Bel Air Md.				DATE SIGNED Sept 19, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 21, 1956		NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		LOCATION (City, town, or county) Bel Air, Harford, Md.	
24. REC'D BY REGISTRAR DATE 9-21-56		REGISTRAR'S SIGNATURE Virgil L. Fowell		25. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son		ADDRESS Abingdon, Md.	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

BUREAU V. 1

SEP 21 1950

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09373

Reg. Dist. No. 185

9375

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>T</u> Last <u>McBride</u>				4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/28/34</u>	9. AGE (In years last birthday) <u>22</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Line man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Utility</u>		11. BIRTHPLACE (State or foreign country) <u>N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Traverse McBride</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. Grace Scriber Harford</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury L. chest</u> DUE TO <u>subcutaneous emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture femur</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-object type</u>					
20c. TIME OF INJURY Hour <u>8:30</u> a. m. <u>  </u> 9/29/56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>on street</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald E Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Harford County</u> 9/30/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CENTRE</u>		22d. LOCATION (City, town, or county) <u>NEW PARK, PA.</u> (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u> ADDRESS <u>Delta, Pa.</u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>10-2-56</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

OCT 4 1936

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9376

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09374

Reg. Dist. No.

ITEM 3:G20

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Avondale</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford &amp; Grace</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) <u>JIBINIAH JOHN</u> First <u>ANDERS</u> Middle <u>McMILLAN</u> Last		4. DATE OF DEATH <u>September 10</u> 19 <u>56</u> Month <u>10</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/14/1926</u>
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Pinney Creek, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>G.F. McMillan</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Burchett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>213-26-6048</u>	
17. INFORMANT <u>L.S. Eastman</u> Address <u>Avondale, Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (a) <u>  </u> stating the underlying cause lost. (b) <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell out of boat</u>	
20c. TIME OF INJURY Month, Day, Year <u>4</u> <u>9/10</u> <u>1956</u> Hour <u>  </u> a.m. <u>  </u> p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Susquehanna River Harford County</u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURNAL CREMATION, REMOVAL (Specify) <u>  </u>		22b. DATE THEREOF <u>9/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fountain Green</u>		22d. LOCATION (City, town, or county) (State) <u>Near Churchville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Eastman</u> ADDRESS <u>Avondale Pa.</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>9-11-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>  </u>	

RECEIVED

1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9377

## CERTIFICATE OF DEATH

09375

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>4 MOS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>200 North Union Ave.</b>		d. STREET ADDRESS <b>North Main St</b>	
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Howard</b> Middle <b>Pugh</b> Last		4. DATE OF DEATH Month <b>Sept.</b> Day <b>21</b> Year <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1869</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Power House</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Howard B. Pugh, 1503 Brandywine Blvd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial failure - &amp; uremia</b> DUE TO <b>Fractured humerus -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic nephritis &amp; uremia -</b> (c) <b>1 day -</b> <b>9 days -</b> <b>5 years -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day -</b> <b>9 days -</b> <b>5 years -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I of 18 <b>Accidental fall injuring ribs &amp; fracturing left arm at shoulder</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell over door sill</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11</b> o. ft. <b>Sept 12</b> p. m. <b>1956</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Havre de Grace Harford Maryland</b>	
21. I certify that I attended the deceased from <b>June</b> , 1956, to <b>Sept 21</b> , 1956, that I last saw the deceased alive on <b>Sept 21</b> , 1956, and that death occurred at <b>10:50 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank Wolbert MD</b>		ADDRESS (Street, city or town, state) <b>Havre de Grace Md</b>	
PHYSICIAN'S NAME (Type) <b>FRANK WOLBERT MD</b>		DATE SIGNED <b>9/21/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/24/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leva Patterson</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 9-23-56</b>		24b. REGISTRAR'S SIGNATURE <b>A. L. Lewis M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LUNDA V. S.

SEP 11 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09376

Reg. Dist. No.

181

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Hartford</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> c. LENGTH OF STAY IN 1b <u>1 year</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R D I</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>R D I</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Clifford</u> Last <u>Quickley</u>				<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>24</u> Year <u>1956</u>													
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>C</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug 30, 1955</u>		<b>9. AGE</b> (In years last birthday) <u>1</u> yr. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Chesden Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>									
<b>13. FATHER'S NAME</b> <u>Joshua G. Quickley</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Beverly G. Scorsion</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> Address <u>Joshua G. Quickley Chesden Md</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>—</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> <u>Gerald C Palmer</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>									
<b>EXAMINER'S NAME (Type)</b> <u>Gerald C Palmer M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<u>9/25/56</u>									
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>																	
<b>22a. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Sept 27, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Union Md Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Chesden Md.</u>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John G. Taring</u>				<b>ADDRESS</b> <u>Chesden Md</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Hellic R. Perry</u>		<b>24b. REGISTRAR'S SIGNATURE</b>									
<b>DATE</b> <u>Sept 27-56</u>																	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED

SEP 1956

BUREAU V. S.

09377

# INSTRUCTIONS

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Hartford</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Shawsville</u>	LENGTH OF STAY (In this place) <u>22 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shawsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>White Hall R.D.</u>		STREET ADDRESS (If rural give location) <u>White Hall R.D.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Heleen A. Richardson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 6 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug 14 1898</u> yrs. <u>63</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elementary</u>	11. BIRTHPLACE (State or foreign country) <u>Norrisville</u>
13. FATHER'S NAME <u>John Wiley Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A. Strawbridge</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-10-100000</u>	
17. INFORMANT & ADDRESS <u>Mrs. Alice R. Robinson</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Insufficiency</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12 May</u> , 19 <u>56</u> , to <u>6 Sept</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6 Sept</u> , 19 <u>56</u> , and that death occurred at <u>8:45 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Thos. C. E. Wooten</u> M.D.		ADDRESS (Street, city, town, state) <u>Warrettsville, Md.</u>	
DATE SIGNED <u>6 Sept 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 8 56</u>	
NAME OF CEMETERY OR CREMATORY <u>Norrisville church</u>		LOCATION (City, town, or county) (State) <u>Norrisville Md.</u>	
24. REC'D BY REGISTRAR DATE <u>9-8-56</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Prudella Lowwood</u> <u>Martha E. Keith</u> <u>Warrettsville</u>	

1. The first part of the paper is devoted to a general discussion of the problem of the existence of a solution of the system of equations (1) for arbitrary values of the parameters  $\alpha$  and  $\beta$ . It is shown that the system has a solution if and only if the condition  $\alpha + \beta = 1$  is satisfied.

11

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# MARYLAND STATE DEPARTMENT OF HEALTH

9390

2411 N. Charles Street, Baltimore

09378

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY Harford		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perryman		CITY (If outside corporate limits, write RURAL and give nearest town) Perryman	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) J.	(Last) Ruane
4. DATE OF DEATH	(Month) Sept.	(Day) 10,	(Year) 19 56
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH July 11, 1875
9. AGE last birthday 81 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Ruane		14. MOTHER'S MAIDEN NAME Cecilia T. Cummings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mr. Joseph H. Nelson		Perryman, Md.	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) *Arterio Sclerotic Cardio Vascular*

##### Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) *Hypertension, Prostate*

(c) *Calculus*

INTERVAL BETWEEN ONSET AND DEATH

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1956, to Sept 10, 1956, that I last saw the deceased alive on Sept 10, 1956, and that death occurred at 5:15 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Sept. 13, 1956	NAME OF CEMETERY OR CREMATORY Cathedral Cemetery	LOCATION (City, town, or county) Baltimore, Md	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FEDERAL DIRECTOR ADDRESS		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be returned to the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9391

## CERTIFICATE OF DEATH

09379

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 9 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital		d. STREET ADDRESS 302 Old Post Road	
3. NAME OF DECEASED (Type or print) First Robert Middle Walter Last Shaffer		4. DATE OF DEATH September 5 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8 1955
9. AGE (in years last birthday) yrs. 8 Months 28 Days		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Joseph Shaffer		14. MOTHER'S MAIDEN NAME Georgenia Dott Erickson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother		Address (same as in 2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Fibrocystic disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH from birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 4 19 56, to Sept 5 19 56, that I last saw the deceased alive on Sept 5 19 56, and that death occurred at 8:05 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Hreidar Agustsson M.D.		DATE SIGNED Sept 5, 1956	
PHYSICIAN'S NAME (Type) HREIDAR AGUSTSSON, Major, MC		ADDRESS (Street, city or town, state) US Army Hospital Aberdeen Proving Ground, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/5/56	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Jamestown New York	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Sarring		ADDRESS aberdeem maryland	
24a. REC'D BY REGISTRAR DATE Sept 7-56		24b. REGISTRAR'S SIGNATURE Nellie G Perry	

2050243385

BOOK NO. 1

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09380

## 9378 CERTIFICATE OF DEATH

Reg. Dist. No. 18.5

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>212 S. Freedom St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>—</u> Last <u>Stansbury</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10th 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Isaac Stansbury</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wm. Stansbury - 612 S. Freedom St. Harford Md.</u>		Address <u>Harford Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>177x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart disease</u> DUE TO <u>Metastatic Carcinoma of Prostate</u> (c) <u>Metastatic Carcinoma of Prostate</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 14, 1956</u> to <u>Sept. 14, 1956</u> , that I last saw the deceased alive on <u>Sept. 14, 1956</u> , and that death occurred at <u>10:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St., Harford Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>9/14/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union W. E. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Karring</u>		ADDRESS <u>Aberdeen Md.</u>	
24a. REC'D BY REGISTRAR <u>9-17-56</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Hansen</u>	

RECEIVED  
SEP 19 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9379

## CERTIFICATE OF DEATH

09381

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. 1 Box 47</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Tazwell</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9, 1901</u>
9. AGE (In years lost birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Columbus, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID SMITH</u>		14. MOTHER'S MAIDEN NAME <u>Cornelius Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give no. or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Howard Tazwell</u>		Address <u>Harve de Grace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>H.T.O.D.</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Hypertensive Arteriosclerotic Heart Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/8</u> 19 <u>54</u> to <u>9/29</u> 19 <u>56</u> , that I last saw the deceased alive on <u>9/29</u> 19 <u>56</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury, M.D.</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St., Harve de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>10/1/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-3-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clara G. Bullock - Harve de Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>C. L. Lewis</u>	
ADDRESS <u>Harve de Grace, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. Lewis</u>	
DATE <u>10-2-56</u>			

BUREAU V. R.

OCT 4 1950

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## 9380 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford Grace</u>		c. LENGTH OF STAY IN lb <u>Nine</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>B + O. RR Tracks</u>		d. STREET ADDRESS <u>529 W Franklin St</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence</u> First <u>Jack</u> Middle <u>Travis</u> Last		4. DATE OF DEATH <u>September 27</u> 19 <u>56</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (Approx) <u>22</u> yrs. 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Evisceration Cerebrum</u> <u>802X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Compound comminuted fracture nearly every bone in body</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by train while walking on RR Tracks</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7</u> Sept <u>24</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>B + O RR Tracks</u>		20f. (City or town) <u>Hartford</u> (County) <u>Harford</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>None</u>		22b. DATE THEREOF <u>9/28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>		22d. LOCATION (City, town, or county) (State) <u>Harford County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hance</u>		ADDRESS <u>Harford County, Md.</u>	
24a. REC'D BY REGISTRAR <u>9-28/56</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-permit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9381

CERTIFICATE OF DEATH

09383

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAUCE DE GRACE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLORA</b>	
c. LENGTH OF STAY IN 1b <b>5 HRS.</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MABEL CATHERINE WEIR</b>		4. DATE OF DEATH Month Day Year <b>SEPT. 26 1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1882</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.S.W.</b>		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE W GRAYSON</b>		14. MOTHER'S MAIDEN NAME <b>RACHEL IRVIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Harry Weir</b>		Address <b>Rising Sun, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Coronary Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b> <b>24 hr.</b> <b>5 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-25-56</b> , to <b>9-26-56</b> , that I last saw the deceased alive on <b>9-25-56</b> , and that death occurred at <b>12:35</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Peter P. Rodman, M.D.</b>		DATE SIGNED <b>9-26-56</b>	
PHYSICIAN'S NAME (Type) <b>Peter P. Rodman, M.D.</b>		<b>Aberdeen, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept 29, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Brookview Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Rising Sun, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Taylor</b>		24a. REC'D BY REGISTRAR <b>U. L. Kavan</b>	
ADDRESS <b>Rising Sun, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>U. L. Kavan</b>	

CERTIFICATE OF DEATH

1956

June 19 1956

BUREAU V. S.

OCT 1 1956

RECEIVED

9382

CERTIFICATE OF DEATH

09384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERLE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Route #2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IDA</u> <u>Mary</u> <u>Wilmer</u>		4. DATE OF DEATH Month Day Year <u>September</u> <u>28</u> <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Samuel Jones</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Chase</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mary B. Gilbert</u>		Address <u>Magnolia Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>10 yr.</u> <u>10 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Stomach with Metastasis to Liver</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 24</u> , 1956, to <u>Sept 28</u> , 1956, that I last saw the deceased alive on <u>Sept 28, 1956</u> at <u>8:35</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.		DATE SIGNED <u>9-28-56</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>		<u>Abingdon, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 30, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Magnolia, Harford Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Mc Comas &amp; Son</u>		24a. REC'D BY REGISTRAR <u>Oct 3-56</u>	
ADDRESS <u>Abingdon Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 8

OCT 4 1956

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